Rx Prescription & Letter of Medical Necessity

Patient Name* _____ **DOB*** _____ **Date of Injury** _____ **Date of Surgery** _____

Primary Phone* _____ **Secondary Phone/ Email** _____

E-Stim

☐  Zynex NexWave + Monthly Supplies and a Conductive Garment when applicable

☐  Zynex E-Wave (NMES Only) + Monthly Supplies

DX Code(s) _____.____ _____.____

Length of Need: ☐Life-time ☐3-18 Months
(if unchecked = Life-time)

Substitution for this device is NOT ALLOWED without my written approval

 Spinal Orthosis (Fill Out Patient Equipment Protocol on Back of Patient Handout)

☐ Horizon Lumbosacral Orthosis (Prefabricated) (Purchase Only) **DX Code(s)** _____.____ _____.____

The Horizon Lumbosacral Orthosis is medically necessary and prescribed to:

- ☐ reduce pain by restricting mobility of the trunk; or
- ☐ facilitate healing following an injury to the spine or related soft tissue: or
- ☐ facilitate healing following a surgical procedure on the spine or related soft tissue; or
- ☐ otherwise support weak spinal muscles and/or deformed spine.

Quantity to be Dispensed: _____ **Frequency of Use:** _____

Please document in patient's chart, the above checked reason(s) for prescribing and fax with Rx

 Cervical Traction  (Fill Out Patient Equipment Protocol on Back of Patient Handout)

☐ Home Cervical Traction (Purchase Only) (Saunders or ComforTrac) **DX Code(s)** _____.____ _____.____

Our Home Cervical Traction Devices are medically necessary because the patient requires greater than 20 pounds of force.

 Hot/Cold Therapy (Fill Out Patient Equipment Protocol on Back of Patient Handout)

☐ JetStream® Hot/Cold circulating pump & therapy blanket **DX Code(s)** _____.____ _____.____

Length of Need: ☐15 Days ☐30 Days ☐45 Days ☐Other ___Days

Treatment Plan (check all that apply): ☐Reduce Pain ☐ Reduce Swelling ☐Improve Blood Flow ☐Improve Range of Motion

I have reviewed the hot/cold therapy contraindications on the back of this prescription prior to prescribing for patient.

Clinic Address _____ City _____ St. _____ Zip _____

Phone _____ Fax _____

Prescriber's Signature* _____ **Date*** _____

Printed Name* _____ **NPI*** _____

☐ _____

If this device was requested by another medical provider, please include their name/address/zip here

I certify that the equipment and supplies I prescribed are Medically Necessary for this patient's well-being; this is NOT prescribed as convenience equipment. In my professional opinion, the equipment is both reasonable and necessary in reference to the accepted standards of medical practice and treatment for this patient's condition. **Substitution for this device is *NOT ALLOWED* without my written approval.**

Fax Rx To: +1 (800) 495-6695 **Email Rx To: orders@zynex.com**

Please Review Hot/Cold therapy contraindications prior to prescribing for patient

CONTRAINDICATION - WHEN NOT TO USE HOT THERAPY

DO NOT use hot therapy on patients with any of the following contraindications:

- History of heat injury or adverse reactions to hot therapy
- Incoherence due to sedation, anesthesia, coma or sleep
- Decreased skin sensitivity or localized circulation or wound healing problems
- Arteriosclerosis or atherosclerosis
- Localized malignancy in treatment area
- Hypersensitivity to heat
- Local tissue infection, swelling or inflammation

DO NOT APPLY ABDOMINALLY IF PREGNANT

CONTRAINDICATION - WHEN NOT TO USE COLD THERAPY

DO NOT use cold therapy on patients with any of the following contraindications:

- History of cold injury, frostbite or adverse reactions to cold therapy
- Incoherence due to sedation, anesthesia, coma or sleep
- Decreased skin sensitivity or localized circulation or wound healing problems, including those caused by multiple surgical procedures
- Circulatory syndromes due to Raynaud's disease, Buerger's disease, peripheral vascular disease, vasospastic disorders, or hypercoagulable clotting disorders
- Hand/wrist or foot/ankle surgery exhibiting polyneuropathy
- Hypersensitivity to cold
- Local tissue infection
- Diabetes

DO NOT USE ON CHILDREN UNDER 12 YEARS OF AGE

Please Fax To: +1 (800) 495-6695

Include Patient Demographics

For LSO orders include patient chart notes supporting Rx

ZYNEX MEDICAL

9555 Maroon Circle

Englewood, CO 80112

Monday - Friday, 6:00 AM – 6:00 PM Mountain

Patient Support: (800) 495-6670

IMPORTANT
GIVE TO PATIENT

HERE'S HOW TO OBTAIN YOUR PRESCRIBED MEDICAL DEVICE

Step 1

- **Zynex will text and call you**

(usually the same day we receive your Rx!)

Step 2

- Have your medical insurance information ready

Step 3

- Zynex will ship your device directly to your home

You can learn how to use the NexWave by watching the instructional video at **http://www.zynex.com/nw**

If you have not heard from us within 24 hours, please call Patient Support at (800) 495-6670

(SEE BACK FOR: EQUIPMENT USE)

Equipment Use Protocol

Patient Name _____

Spinal Bracing Equipment Use Protocol

Pain Management Use

☐ Wear ____ min./day and increase wear time by ____min. every ___day(s)

☐ Wear spinal brace while performing the following:

☐ Sitting ☐ Standing ☐ Walking ☐ Exercising ☐ Other_____

Instructions:_____

_____

Post Operative Use

☐ Day ____ through Day ____ Wear continuously with a break of ____min. every ____hour(s)

☐ Day ____ through Day ____ Wear continuously with a break of ____min. every ____hour(s)

☐ Wear spinal brace while performing the following:

☐ Sitting ☐ Standing ☐ Walking ☐ Exercising ☐ Other_____

Instructions:_____

_____

Cervical Traction Equipment Protocol (Tx = Treatment)

Choose Degree of Flexion: ☐ **10°** ☐ **15°** ☐ **20°**

☐ **Tension Type:** Sustained ____lbs. of Force ____min./Tx ____Tx/Day

☐ **Tension Type:** Intermittent ____lbs. of Force ____min. of ON Time ____min. of OFF Time ____Tx/day

Hot/Cold Therapy Equipment Use Protocol (Tx = Treatment)

Cold Therapy (40° - 50°):

☐ Day ____ through Day ____ Use continuously with a break of ____min. every ____hour(s)

☐ Day ____ through Day ____ Use: ____min./Tx every ____hour(s)

☐ Use after exercise for ____min./Tx

Hot Therapy: (80° - 120°)

☐ Use after day number____ ☐ Before exercise: ____min./Tx

☐ Loosen stiff muscles/Joint: ____min./Tx

See Back For: "How to Obtain Your Prescribed Device"